MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-22)

12200

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred: Reeves Clinic

How long in hospital or institution? 17 ds.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cemetery Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lonie Marion Beckner

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Arrie Beckner

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Dec 3, 1866

8. AGE: Years: 74 Months: 0 Days: 6 If less than one day: ..... hrs. ..... min.

9. Birthplace: Gaskens-Rockbridge-Va
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Own Business

FATHER
12. Name: William Beckner
13. Birthplace: not known

MOTHER
14. Maiden name: Nellie Mackrom
15. Birthplace: Virginia

16. Informant: B R Beckner

Address: Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11 1940 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Dec. 10 1940 (Date rec'd by registrar) A J Faymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15th 1940, to Dec. 9th 1940 and that I last saw him alive on Dec 9th 1940

Immediate cause of death: Hypostatic Pneumonia, & Uremia

Due to: Head injury - (accident of fall)

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L W Reeves M. D. or other

Address: Westernport Md Date signed: 12-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

CERTIFICATE OF DEATH

12201

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.
Hospital, Institution, or street address where death occurred:
201 Springdale St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Springdale Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Beeche.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.) November 26, 1894

8. AGE: Years	Months	Days	If less than one day
46	0	10	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name James Beeche
13. Birthplace Maryland

MOTHER 14. Maiden name Louise Taylor
15. Birthplace Maryland

16. Informant Louise Taylor
Address 201 Springdale St.

17. burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7, 1940 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery
Location Cumberland, Maryland

18. Funeral director Louis Stein Inc.
Address Cumberland Maryland

19. Dec 6 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1940, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1939 December 5 1940
and that I last saw h-im alive on December 5 1940

Immediate cause of death	DURATION
Congenital	46 yrs.
Due to Hydrocephalus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D.
M. D. or other
Address Cumberland, Md. Date signed 12/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

12202

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BEEMAN, REBECCA (COOK)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife GEORGE BEEMAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 27, 1872

8. AGE: Years	Months	Days	If less than one day
68	8	19	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

FATHER 12. Name JAMES COOK

13. Birthplace SCOTLAND

MOTHER 14. Maiden name REBECCA

15. Birthplace SCOTLAND

16. Informant Joseph Beeman

Address Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18, 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Lonaconing

18. Funeral director J. H. Eichhorn

Address Lonaconing, Md.

19. Dec 18 1940 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

DR. WILSON

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 16, 1940, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-4-1940 to 12-16-1940

and that I last saw her alive on 12-15-1940

Immediate cause of death	DURATION
Pneumonia of Liver	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams M. D. or other

Address Cumberland Date signed 12/16/40

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BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12203

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town R.F.D. #5 Fair grounds near Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Fair grounds

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. RFD #5 Fair grounds
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Nellie May "Coffman" Berry

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Edward Berry

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 6, 1875

8. AGE:

Years	Months	Days	If less than one day
65	7	3	____ hrs. ____ min.

9. Birthplace Moorefield, W. Va.
(Town, county, and state)

10. Usual occupation Sewing

11. Industry or business W.P.A. project

FATHER 12. Name John Coffman

FATHER 13. Birthplace Moorefield W. Va.

MOTHER 14. Maiden name Catherine Arndaffl

MOTHER 15. Birthplace Moorefield W. Va.

18. Informant Mrs. Hilda Van Meter

Address Fair Grounds RD#5 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12, 1940 (month) (day) (year)

Cemetery or crematory Duling Cemetery

Location Near Keyser, W. Va.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Dec 12 1940 (Date rec'd by registrar) Jos. L. Franklin M.D. Registrar

Mrs B Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1940, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940 to Dec 9 1940 and that I last saw h[illegible] alive on Dec 9 1940

Immediate cause of death Cerebral apoplexy

DURATION

Due to Arterio sclerosis about 2 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mrs B Owens M. D. or other

Address 1337 4th Ave Date signed 12/14/40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12204

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred: 611 Louisiana ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 526 Broadway Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ada Eliza Bishop

3. (b) Social Security Number None

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): October 5, 1862

8. AGE: Years 78 | Months 2 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: Eckhart Allegany Co Md
(Town, county, and state)
10. Usual occupation: House duty
11. Industry or business: Own House
FATHER
12. Name: John Bishop
13. Birthplace: Redruth, England
MOTHER
14. Maiden name: Mary Elizabeth Pearce
15. Birthplace: Paw Paw W Va
16. Informant: Miss Leah Taylor
Address: 611 Louisiana ave City
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27/40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland Md
18. Funeral director: William H. Kight
Address: Cumberland Md.
19. Dec 27 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25th 1940 at 7.15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death: Coronary sclerosis –	?
Due to	
Due to	
Other conditions: cystic Goitre. Arteriosclerosis, –	years.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: James E. McLean M.D. M.D. or other
Address: 49 Greene St Cumberland Md Date signed 12-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

12205

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred: 101 Penn. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Pennsylvania Ave (If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Cecelia Martha Blank

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: John Edward Blank

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 14, 1857

8. AGE: Years: 83 Months: 8 Days: 21 If less than one day ..... hrs. ..... min.

9. Birthplace: Cherry Run Va. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: at home

FATHER
12. Name: John Orndorf
13. Birthplace: Cherry Run. Va.

MOTHER
14. Maiden name: Jane Triplet
15. Birthplace: Winchester Va.

16. Informant: Howard T. Blank

Address: Cumberland. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7, 1940 (month) (day) (year)

Cemetery or crematory: Episcopal Cem.

Location: Mt. Savage

18. Funeral director: Jacob Hafer

Address: Cumberland - Md

19. December 7 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5 1940, at 11:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1940 to Dec 5 1940 and that I last saw h. w alive on Dec 5 1940

Immediate cause of death: General Arteriosclerosis

Due to: age

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: 1934

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 133 Va Ave Date signed: 12/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12206

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County ALLEGANY Registration Dist. No. 4

Village or City Cumberland No. 300 Bedford St. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Charles August Boni

(a) Residence: No. 300 Bedford St., Ward. Social Security No. None

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
MALE	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of ANNA M. SCHILLER

6. DATE OF BIRTH (month, day, and year) June 6, 1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	6	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Express Agent

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Retired

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation 32

12. BIRTHPLACE (city or town) Grantsville (State or country) Garrett Co Md.

FATHER

13. NAME August Boni

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Sophie Winterburg

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Mrs. Anna M. Schiller (Address) 300 Bedford St.

18. BURIAL, CREMATION, OR REMOVAL Place Grantsville Date Dec. 16, 1940

19. UNDERTAKER U. L. Lemperuer (Address) 202 Green St.

20. FILED Dec 16, 1940 Jos. P. Franklin M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December (Month) 13 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1940, to Dec 13, 1940

I last saw h.im alive on Dec 14, 1940; deeth is said to heve occurred on the date steted above, at 10:30 A.m.

The **PRINCIPAL CAUSE OF DEATH** end related causes of importance were as follows:

	Date of onset
Cerebral Hyperatrophy	2 yrs.
Apoplexy	1½ yrs
Other Contributory Causes of Importance:	
Bronchio pneumonia	3 days

Name of operetion ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did Injury occur? ... (Specify city or town, county and State)

Specify whether injury occurrad In INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Wes disease or Injury In any way related to occupation of deceesed? ...

If so, specify ...

(Signed) D. G. Moore M.D. M. D.

(Address) Medical Bldg

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 6, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED JAN 1 1941 BUREAU OF

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

CHANGE in name of wife (and informant) made thru letter in permanent file February 1, 1941 under Dr. Grove. - L.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

12207

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

118 Elder St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 Elder St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ida Grace Breighner

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jerome A. Breighner

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): April 12 1861

8. AGE: Years	Months	Days	If less than one day
79	8	8	....hrs. ....min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home.

FATHER — 12. Name: Wm Stonaker

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Rebecca Yeager.

MOTHER — 15. Birthplace: Pa.

16. Informant: Mrs Edward R Hahne.

Address: Cumberland.

17. Burial. Date thereof: Dec 13 '40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Dec 21 19 40 Jos P Franklin MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 19 40 at 1420 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 19 40 to Dec 20 19 40 and that I last saw h... alive on Dec 20 19 40

Immediate cause of death	DURATION
Arteriosclerosis	3yrs
Due to: age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

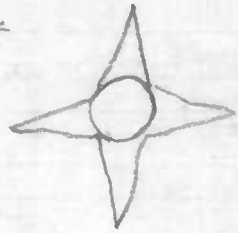
23. SIGNATURE: Wm S Owens M. D. or other

Address: 133 Va Ave Date signed: Dec 21 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15



RECEIVED
JAN 7 1941
BUREAU V. S.

12208

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Barton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Catherine Broadwater

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John Broadwater

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1865

8. AGE: Years: 75 | Months: 2 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Firm Rock, Allegany, Md. Westernport (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home.

FATHER
12. Name: Jessie Michacel
13. Birthplace: Firm Rock, Westernport, Md.

MOTHER
14. Maiden name: Eliza Jenkins
15. Birthplace: Garrett County

16. Informant: Cecil Broadwater

Address: ~~Broadwater~~ Barton

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6 1940 (month) (day) (year)

Cemetery or crematory: Michacel's Cem - Firm Rock

Location: Firm Rock, near Westernport, Md.

18. Funeral director: Mrs. Fay Boal Berry

Address: Westernport, Md.

19. Dec 4 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3rd 1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1943, to Dec 2d 1940 and that I last saw her alive on Dec 2nd 1940

Immediate cause of death: Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing Md. Date signed: Dec 4th 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

122097

Reg. Dist. No.

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days): 8 hours
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Broadway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: "

3. (a) FULL NAME: Frances Vincent Broderick

3. (b) Social Security Number: 220-10-2063

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: "

6 (c) If alive, give age: " years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1886

8. AGE: Years: 54 | Months: 8 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Vale Summit (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER
12. Name: William F. Broderick
13. Birthplace: Vale Summit Md

MOTHER
14. Maiden name: Isabel Thompson
15. Birthplace: Claysville Md.

16. Informant: William J. Broderick
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19 1940 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Westernport, Md.

18. Funeral director: M. E. Jackson
Address: Lonaconing, Md.

19. Dec. 18 (Date rec'd by registrar) 19 40 Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1940, at 1045 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1940, to December 16 1940, and that I last saw h in alive on December 16 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions: Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M.D.
M. D. or other
Address: Midland, Md. Date signed 12-17-40

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

12210

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: 117 Independence St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Independence
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Belle Browning

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Basil Browning

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15 1856

8. AGE: Years 84 | Months 2 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Uniontown Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER
12. Name: Simeon Houser
13. Birthplace: Pa.

MOTHER
14. Maiden name: Millie J Chaney
15. Birthplace: Pa.

16. Informant: Rebecca Watkin

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 17 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Dec 17 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14 1940, at 10 30/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1940, to Dec. 14 1940 and that I last saw her alive on Dec 13 1940

Immediate cause of death	DURATION
Chronic Nephritis	1935
Chronic Myocarditis	1935
Due to Arterio Sclerosis	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. E. Eleason M.D. M. D. or other

Address: Cumberland Md. Date signed 12/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1146)

CERTIFICATE OF DEATH

12211

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 220 Union St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Union St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward L Casey

3.(b) Social Security Number 214-07-5467

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Jane Hamilton

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1892

8. AGE: Years	Months	Days	If less than one day
48	7	0	hrs. min.

9. Birthplace USA Frostburg Md. (Town, county, and state)

10. Usual occupation Celenese.

11. Industry or business

FATHER 12. Name Patrick Casey

FATHER 13. Birthplace Scranton Pa.

MOTHER 14. Maiden name Mary Coleman

MOTHER 15. Birthplace Somerset Pa.

18. Informant James Casey

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2 40 (month) (day) (year)

Cemetery or crematory St Thomas Cemetery

Location Thomas, West Va.

18. Funeral director Lewis Stein Inc.

Address Cumberland Md.

19. Dec 30 19 40 Jos P Franklin M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1940, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1940, to Dec 29 1940 and that I last saw h. alive on Dec 29 1940

	DURATION
Immediate cause of death Dilatation of the heart	
Due to Mamars asthma	several yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 125 Bedford St Date signed 12-29-40

RECEIVED
JAN 7 1941
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-A)

CERTIFICATE OF DEATH

12212

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R. L. & P.
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R. F. D. 1
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Elizabeth Clancy

3. (b) Social Security Number: None

4. Sex: F.
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Late Theodore
6(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Oct 20 - 1869
8. AGE: Years: 71 | Months: 1 | Days: 27 | If less than one day: ___ hrs. ___ min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Daniel Gray
13. Birthplace: Md
MOTHER 14. Maiden name: Margaret Himan
15. Birthplace: Md
16. Informant: Mrs. Naomi Briggs
Address: Cumberland Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Dec 21 - 40 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul Cem.
Location: Cumberland Md
18. Funeral director: V. L. Lamparama
Address: Cumberland, Md
19. Dec 20 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1940, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Sept~~ 1940 to Dec. 17 1940, and that I last saw h~~e~~r alive on Dec. 15 1940
Immediate cause of death: Carcinoma of Cervix — DURATION: 1937
Due to: Uremia — Urinary Retention — 10 days
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: W Rope Hodges, M.D. M. D. or other
Address: Cumberland, Md Date signed: 12/13/1940

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 46-B

Reg. Dist. No. 7

CERTIFICATE OF DEATH

12213

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Cattail (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 65 years

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State md (b) County Alleghany Co

(c) City or town Barton (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Charles Edward Clark

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mollie Snyder Clark

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1871

8. AGE: Years 69 | Months 10 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Lonaconing, Alleg, Md. (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

FATHER

12. Name George Clark

13. Birthplace Martinsburg, W. Va

MOTHER

14. Maiden Name Mary Mc Donald

15. Birthplace Martinsburg W. Va

16 (a) Informant Mrs. Mollie Clark

(b) Address Barton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30, 1940 (month) (day) (year)

(c) Cemetery or crematory Laurel Hill Cem.

Location Mascow, Md.

18 (a) Funeral director Ray Boal Berry

(b) Address Westernport, Md.

19 (a) Dec 27 (Date rec'd by registrar) (b) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 26 1940, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940, to Dec 26 1940, and that I last saw him alive on Dec 26 1940.

Immediate cause of death	Duration
Cachexia	10 days
Due to Carcinoma of Stomach	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph Friedman M. D. or other

Address Westernport Date signed Dec 27, 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JAN 6 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

12214

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Stillborn

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? Stillborn

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 879 Patterson ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME Baby Clayton (Stillborn)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~M~~	W	Stillborn

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 8, 1940

8. AGE:

Years	Months	Days	If less than one day
0	0	0	0 hrs. 0 min.

9. Birthplace Cumberland, Allegany, Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Sterling Golden Clayton

13. Birthplace Horton, W. Va.

MOTHER 14. Maiden name Leola Pearl ~~Hinkle~~

15. Birthplace Rural near Romney, W. Va.

16. Informant Sterley Clayton

Address 879 Patterson ave. Cumberland

17. Burial Date thereof Dec 10, 1940

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hendricks Cemetery

Location Hendricks W. Va.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Dec. 9 1940 Jos. P. Franklin M.D. Registrar

(Date rec'd by registrar)

Dr. Hunter

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1940, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .....19....., to .....19.....

and that I last saw h.....alive on .....19.....

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE T. Bailey Hunter M.D.

M. D. or other

Address Cumberland, Md. Date signed 12/8/40

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

12215

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margret Close

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) aug 23 - 1861

8. AGE: Years	Months	Days	If less than one day
79	4	2	..... hrs. ..... min.

9. Birthplace Eckhart - alleg - md.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name James Close

13. Birthplace Scotland

MOTHER 14. Maiden name Margret Dudley

15. Birthplace Scotland

16. Informant James D. Close

Address Frostburg md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28-1940 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg md.

18. Funeral director J. L. Burns

Address Frostburg, md

19. Dec, 28 1940 (Date rec'd by registrar) mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1940, at 9 00 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1940 to Dec 25 1940

and that I last saw h.. alive on Dec. 25 1940.

Immediate cause of death	DURATION
Acute myocarditis	1 hr.
Due to Chronic arthritis	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W E Gattens M.D. M. D. or other

Address Frostburg Md. Date signed 12/27/40

RECEIVED
JAN 3 1941
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

83-a

9

12215

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Frost Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Margaret Reed Condry

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Martin Condry

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Feb. 16th. 1864

8. AGE: Years 72 | Months 9 | Days 23 | If less than one day .....hrs. .....min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business .....

FATHER 12. Name Geo. Chapperman

13. Birthplace Scotland

MOTHER 14. Maiden name Jean Walker

15. Birthplace Scotland

16. Informant Irene Condry Frostburg Md

Address 5 Frost Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11th 1940 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg, Md.

18. Funeral director Jacoff Kaster

Address Frostburg, Md.

19. Dec. 10th 1940 (Date rec'd by registrar) Mrs. A. C. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1940, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to Dec 9 1940 and that I last saw her alive on Dec 7 1940

Immediate cause of death	DURATION
Hypertension	7
Due to	1
Due to Cerebral Hemorrhage	2 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. D. M. Lane Jr. M.D. M. D. or other

Address Frostburg Md Date signed Dec 10 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12217

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penn County: Bedford

City or town: Artemas
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Artemas
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Stillborn Conrad

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): December 31, 1940

8. AGE: Years: Newborn | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Cumberland Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Earl Conrad
13. Birthplace: Artemas, Penn

MOTHER
14. Maiden name: Oliva Virginia Browning
15. Birthplace: Artemas, Penn

16. Informant: Mr. Earl Conrad
Address: Artemas, Penna

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1940 (month) (day) (year)

Cemetery or crematory: Artemas Cem

Location: Artemas, Penna

18. Funeral director: E. R. Smith
Address: Artemas, Penna

19. Dec. 31, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1940, at 7 58/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 1940 to Dec 31 1940 and that I last saw her alive on Stillborn 19

Immediate cause of death: Intrauterine Asphyxia

Due to: Placenta Previa

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 40 N. Liberty St. Date signed: 12-31-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

12218

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs.

Hospital, institution, or street address where death occurred: 222 G. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 G Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stanley P. Cooper

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mary Denison

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan 19 1873

8. AGE: Years	Months	Days	If less than one day
67	11	7	....hrs. ....min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Baker

11. Industry or business

FATHER 12. Name Samuel Cooper

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Brown

15. Birthplace Md.

16. Informant Mrs Mary Cooper.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Dec 30 1940 (Date rec'd by registrar) Jas. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1940, at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 25th 1940, to Dec 26 1940 and that I last saw him alive on Dec. 26th 1940

Immediate cause of death	DURATION
Pneumonia	
Lobar Type.	
Due to —	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. —

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE J. T. Langston M. D. or other

Address 54 N. Mechanic Date signed 12-30-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142)

CERTIFICATE OF DEATH

12219

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JOHN J. DAWSON

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: VIRGINIA LEE GULICK
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): JULY 23, 1872

8. AGE: Years	Months	Days	If less than one day
68	5	1	....hrs. ....min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)
10. Usual occupation: TAILOR
11. Industry or business
FATHER 12. Name: HANSEL DAWSON
13. Birthplace: WEST VIRGINIA
MOTHER 14. Maiden name: ELIZABETH RODRUCK
15. Birthplace: WEST VIRGINIA
16. Informant: Mrs Ray C. Wilson
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26 1940 (month) (day) (year)
Cemetery or crematory: Indian Mound Cem
Location: Romney W Va.
18. Funeral director: Lovell Stein Inc
Address: Cumberland Md
19. Dec 26 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24, 1940, at 5:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1940, to Dec 24 1940 and that I last saw him alive on Dec 24 1940

Immediate cause of death	DURATION
(a) Renal Arteriosclerosis	?
Due to, (b) Renal Arteriosclerosis	
Due to, (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Royce Hodge, M D, M. D. or other
Address: Cumberland, Md Date signed: 12/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12220

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 yrs
Hospital, Institution, or street address where death occurred: 402 N. Centre St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 402 N Centre St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Henry Diebold

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Lewis
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Oct 16 1860

8. AGE:

Years	Months	Days	If less than one day
80	1	17	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business:
FATHER 12. Name: George Diebold
13. Birthplace: Germany.
MOTHER 14. Maiden name: Mary Stemmer
15. Birthplace: Md.
16. Informant: George Diebold
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5 40 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland Md
18. Funeral director: Louis Sterne Inc
Address: Cumberland
19. Dec 5 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1940, at 4 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1940, to Dec 3 1940
and that I last saw him alive on Dec. 1, 1940

Immediate cause of death	DURATION
(a) Cancer of Stomach	
Due to (b) Exhaustion	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph P. Franklin M. D.
M. D. or other
Address: Cumberland Md Date signed: 12/5/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

12221

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 608 Col Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 608 Columbia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Dietrich

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Sarah Sofie Grimm

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 2 1855

8. AGE: Years: 85 | Months: 11 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Farmer (Retired)

11. Industry or business

FATHER
12. Name: Geo Dietrich
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Metzner
15. Birthplace: Germany

16. Informant: Charles H Dietrich
Address: Cumberland Md.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Dec 31. 40
(month) (day) (year)

Cemetery or crematory: St Peter & Paul

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc
Address: Cumberland Md.

19. Dec 31 1940
(Date rec'd by registrar)
Jos P Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1940, at 12 40/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27/40 19 to 12/29/40 19 and that I last saw him alive on 12/29/40 19

Immediate cause of death: Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John K Rymer M.D.
M. D. or other

Address: 12 Decatur St Cumberland Md. Date signed: 12/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12222

(107)

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If ontside city or town limits, write RURAL nnd give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 N. Mechanic St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Alonzo Everstine

3. (b) Social Security Number None.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: Catherine Williams

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 4 1870

8. AGE: Years: 70 | Months: 7 | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: General.

FATHER — 12. Name: George Everstine

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Clara J. Valentine

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs Carl Knight

Address: Bedford Rd.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 27 '40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Dec 27 1940 Jos. P. Franklin M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-25- 1940, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-25- 1940 to 12-25- 1940

and that I last saw him alive on 12-25- 1940

	DURATION
Immediate cause of death: Broncho Pneumonia	?
Due to: Due Hospital	
Due to: About 5 Days	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed: 12/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

12223

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WEST VIRGINIA County: HARDY

City or town: FABIUS
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: MRS. LUCY ADAMS FUNK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: FLOYD FUNK

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): APRIL 21, 1906

8. AGE:

Years	Months	Days	If less than one day
34	7	16	hrs. min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: SIMON ADAMS
13. Birthplace: W.VA.

MOTHER
14. Maiden name: VIRGINIA OLIVE
15. Birthplace: W.VA.

16. Informant: Floyd W. Funk
Address: Fabius, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10, 1940 (month) (day) (year)

Cemetery or crematory: Asbury Cem

Location: Hardy Co.

18. Funeral director: W H McKee

Address: Augusta, Wva

19. Dec 9 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

DR. GRACIE

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 7, 1940, at 3:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1940, to Dec 7 1940 and that I last saw her alive on Dec 7 1940

Immediate cause of death: Cerebral Embolism

Due to: Hysterectomy

Due to: Laparotomy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Fibroids - Gall stones

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. G. Gracie M. D. or other

Address: Cumberland — Date signed: Dec 8-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-A) Reg. Dist. No. 6

CERTIFICATE OF DEATH

12224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
(a) County Allegany
(b) City or town Westernport (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 417 Maryland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) Entire time
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Westernport (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Maryland Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Michael Alphonsus Getty

3 (b) If veteran, name war

3 (c) Social Security No. 705-10-7851

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret L. Getty

6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1873

8. AGE: Years 67 | Months 11 | Days 25 | If less than one day ____ hr. 30 min.

9. Birthplace Westernport Allegany Md (Town, county, and state)

10. Usual occupation Agent, Operator, Clerk

11. Industry or business Railroads

FATHER
12. Name John W. C. Getty
13. Birthplace Georgetown, D.C.

MOTHER
14. Maiden Name Mary C. Koontz
15. Birthplace Lonaconing Md

16 (a) Informant John W. Getty
(b) Address Westernport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1940 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Westernport, Md.

18 (a) Funeral director Jay Ford Berry
(b) Address Westernport, Md.

19 (a) Dec. 28, 1940 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 26 1940, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1940, to Dec. 26 1940, and that I last saw him alive on Dec. 25 1940.

	Duration
Immediate cause of death Uremia	2 Days
Due to Chronic Nephritis with Edema	3 Months
Due to Arteriosclerosis And Hypertension	6 Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Wilson M.D. (M. D. or other)
Address Piedmont, W. Va. Date signed 12-27-40

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12225

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 3 Waverly Terrace.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Waverly Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Phineas D. Getzendanner

3. (b) Social Security Number 214-07-0190

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wilhelmina Herpich

~~March 7~~ 6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.): March 7, 1870

8. AGE: Years 70 Months 9 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual occupation Stationary Engineer

11. Industry or business Kelly Springfield Tire Co

FATHER
12. Name Phineas Getzendanner
13. Birthplace Frederick Maryland

MOTHER
14. Maiden name Sarah Weeks
15. Birthplace Frederick Maryland

16. Informant Clarence Getzendanner

Address Baltimore Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 31 1940 (month) (day) (year)

~~Cemetery or~~ crematory St Peters & Paul

Location Fayette St Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Maryland

19. Dec 31 1940 (Date rec'd by registrar) Jos P Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1940 at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1940, to Dec. 28 1940 and that I last saw him alive on December 28 1940

Immediate cause of death	DURATION
Chronic Endocarditis	1925
Chronic Myocarditis	1925
Due to Arteriosclerosis	1925
Chronic Interstitial Nephritis	1935
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Chasan M.D. M. D. or other

Address 126 Fremont St Cumberland Md Date signed 12/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Earle

12226 9

Reg. Diat. No.

WITHIN CORPORATE LIMITS

93-d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 35 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Glotfelty

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 13, 1845

8. AGE: Years 95 | Months 5 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Md. - Allegany County (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Leonard Fratz

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace:

16. Informant: Mrs. Elizabeth Barney, Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22 1940 (month) (day) (year)

Cemetery or crematory: Accident Cemetery

Location: Accident, Md.

18. Funeral director: J. J. Hurst

Address: Frostburg, Md.

19. Dec. 21 st 1940 (Date rec'd by registrar) Mrs. C. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1940, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1940, to 1940, and that I last saw h... alive on Dec 19 1940.

Immediate cause of death	DURATION
Bronchopneumonia	
arteriosclerotic Heart	
Due to Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. M. Earle Jr. M.D. M. D. or other

Address: Frostburg, Md. Date signed: 12-21-40

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

12227

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 3 hrs

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 28 Orchard St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Thomas H. Gray

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1859

8. AGE: Years 81 Months 10 Days 23 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation R.R. Trainman

11. Industry or business Retired

FATHER 12. Name Thomas Gray

13. Birthplace Maryland

MOTHER 14. Maiden name Not Known

15. Birthplace Maryland

16. Informant Mrs Harry Abbott

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18-1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

18. Funeral director V. L. Lempereur

Address Cumberland, Md.

19. Dec 17 1940 (Date rec'd by registrar) Jos P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1940, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1940, to Dec 13 1940, and that I last saw him alive on Dec 13 1940.

Immediate cause of death Empyema (Left chest) — DURATION 3 days.

Due to Lobar Pneumonia — 13 days.

Due to Lower left

Other conditions Myocardial Disease Arteriosclerosis (Include pregnancy within 3 months of death)

Major findings: Of operations Thoracentesis. Produced greenish gray thick fluid

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel M. Jacobson M.D. M. D. ~~or other~~

Address 119 Bedford St. Date signed 12/16/40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

CERTIFICATE OF DEATH

John H. Guinard

12228

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
50 Greene Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 50 Greene Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War Veteran

3. (a) FULL NAME: JOHN HENERY GUINARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leota Hendrickson
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 5, 1901

8. AGE: Years	Months	Days	If less than one day
39	5	1	hrs. min.

9. Birthplace: Davis, West Virginia (Town, county, and state)
10. Usual occupation: brick insulation contractor
11. Industry or business:
FATHER 12. Name: John Guinard
13. Birthplace: Dubois, Pa.
MOTHER 14. Maiden name: Mary Donaldson
15. Birthplace: Dubois, Pa.
16. Informant: Leota H. Guinard
Address: 50 Greene St.
17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest
Location: Baltimore Pike
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland
19. Dec 6 1940 (Date rec'd by registrar) Joseph P. Dobelin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5th., 1940, at about 3.30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Strangulation	
Due to:	
Due to:	
Other conditions: epilepsy	lifetime.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 12/5/40
Where did injury occur? Cumberland, Allegany, Maryland.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Fall, during epileptic seizure Injured at work? yes
A fall from ladder while painting in bathroom

23. SIGNATURE: Louis H. Bowen, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 12/5/40
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 2 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: R.F.D. Mt Savage Road
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Helmstetter

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: William Helmstetter

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 27 1871

8. AGE: Years 69 | Months 4 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Augustus Burkey
13. Birthplace: Ohio

MOTHER
14. Maiden name: Rose Mattingly
15. Birthplace: Pa

16. Informant: William Helmstetter
Address: Mt Savage Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3 1941 (month) (day) (year)

Cemetery or crematory: St. Pat. Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Jan. 2, 1941 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1940, to December 31 1940 and that I last saw her alive on December 31 1940

Immediate cause of death	DURATION
Influenza	3 wks?
work Influenzal Pneumonia	
Agranulocytosis Probably	
~~Due to~~ caused by antecedent	3 wks?
Uremia	???
~~Due to~~ Severe Secondary Anemia	???
Myocardial	???
Other conditions: Terminal Pulmonary	
Edema	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Samuel H. Jacobson MD M. D. or other

Address: 119 Bedford St. Date signed 1/2/41

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-a)

CERTIFICATE OF DEATH

12230

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mayyland County: Allegany
City or town: Oldtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bernice E. Hose

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 13, 1908

8. AGE: Years	Months	Days	If less than one day
32	0	0	hrs. min.

9. Birthplace: Oldtown, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jonah Hose
13. Birthplace: Oldtown, Md.

MOTHER
14. Maiden name: Hope Pope
15. Birthplace: Oldtown, Md.

16. Informant: Jonah Hose
Address: Oldtown, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15, 1940 (mo.) (day) (year)
Cemetery or crematory: Oldtown Cemetery
Location: Oldtown, Maryland

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland

19. Dec 16 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1940, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1940, to Dec. 13 1940
and that I last saw h.er alive on December 13 1940

Immediate cause of death	DURATION
Bacterial Endocarditis	3 weeks ??
Myocarditis. (acute)	3 weeks ??
Due to: (cause undetermined)	
Due to:	
Other conditions: Acute Nephritis	2 weeks.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Partial Autopsy Final Report not available
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Davidson M.D. M. D. or other
Address: 119 Bedford St. Date signed: 12/14/40

RECEIVED
JAN 7 1941
BUREAU V. S.

12231

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred: 431 Walnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Md. Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 431 Walnut
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grover Marshall Cleveland Hott

3.(b) Social Security Number 216-05-0715

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Sadie A. Hott

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.): November 27, 1884

8. AGE: Years 56 | Months 1 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace: Augusta Hampshire, W. Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: W. Va Pulp & Paper Mill

FATHER
12. Name: John Hott
13. Birthplace: Augusta, W. Va.

MOTHER
14. Maiden name: Jemima (Hott) Hott
15. Birthplace: Augusta, W. Va.

16. Informant: Mr. Leo Hott

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1940 (month) (day) (year)

Cemetery or crematory: Philos Cem.

Location: Westernport, Md.

18. Funeral director: Fay Boal Berry

Address: Westernport, Md.

19. Dec. 28 1940 (Date rec'd by registrar) A. Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 27, 1940, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1940, to Dec 27, 1940 and that I last saw him alive on Dec 27, 1940

Immediate cause of death: Bronchio-pneumonia (terminal) — DURATION: 1 day

Due to: Chronic Myocarditis — 2 wks

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas Reeves, M.D. M. D. or other

Address: Westernport Md. Date signed: 12.27.40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12232

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Spruce St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jesse Hunter

3. (b) Social Security Number 214-12-3170

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary E Smith

6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.): Not known 1918

8. AGE: Years 22 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace U S A
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business General work

FATHER
12. Name McKinsey Hunter
13. Birthplace Virginia

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mary E Hunter

Address 15 Spruce St Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec 1940
(month) (day) (year)

Cemetery ~~or crematory~~ Summer

Location Dale St Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Maryland

19. Dec 31 1940
(Date rec'd by registrar)

Joe P Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1940, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1940, to Dec 28 1940 and that I last saw him alive on Dec 28 40 19

Immediate cause of death

Cerebro Spinal Syphilis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Medical Bldg Date signed 2880

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Mathews

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

CERTIFICATE OF DEATH

12233

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, Institution, or street address where death occurred:
643 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 643 Columbia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Martin Kearney

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Comer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 22, 1859

8. AGE: Years	Months	Days	If less than one day
81	2	9	..... hrs. ..... min.

9. Birthplace: Franklin, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Coal Mines

FATHER
12. Name: Luke Kearney
13. Birthplace: Carbondale, Pa.

MOTHER
14. Maiden name: Mary Howarth
15. Birthplace: England

16. Informant: Edward J. Kearney
Address: 643 Columbia Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1941 (month) (day) (year)

Cemetery or crematory: St. Michaels
Location: Frostburg, Md.

18. Funeral director: Jacob J. Hafer
Address: Cumberland, Md.

19. Jan 1 1941 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1940, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 1940, to Dec. 30 1940 and that I last saw h... alive on Dec. 20 1940

Immediate cause of death	DURATION
Uremia Coma	1 Day
Due to Chronic Endocarditis	1 Yrs
Due to Chronic Nephritis	1 Yrs
Other conditions Dr Pneumonia	2 Wks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward J. Kearney M. D. or other

Address: Cumberland Md. Date signed 12/31/40

RECEIVED
JAN 7 1941
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12234

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Uhl Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cedartown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Uhl Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Kelley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Ada B Peake

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 13 1878

8. AGE: Years	Months	Days	If less than one day
62	8	2	....hrs. ....min.

9. Birthplace: Hampshire Co West Va (Town, county, and state)

10. Usual occupation: Stonemason

11. Industry or business: General mechanic

FATHER — 12. Name: Ed Kelley

FATHER — 13. Birthplace: Hampshire Co West Va

MOTHER — 14. Maiden name: Rhoda E Whitacre

MOTHER — 15. Birthplace: Hampshire Co West Va

16. Informant: Connell Kelley

Address: Berkley Spring West Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27 1940 (month) (day) (year)

Cemetery or crematory: Cemetery Funeray

Location: Berkley Spring West Va

18. Funeral director: James Stein Inc

Address: Cumberland Md

19. Dec 26 1940 (Date rec'd by registrar) Jos. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1940 at 7 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Automobile accident	Instant death
Due to	
Due to	
Other conditions	

(Includa pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Dec 24-40

Where did injury occur? Route 51 - 5 miles East of Cumberland (City or town) Allegany (County) (State) Md.

Injured at home, farm, industry, public place (where?)

Means of injury: Automobile struck him Injured at work? no

23. SIGNATURE: R. H. Trevaskis, M.D.

acting Deputy Medical Examiner Allegany Co. M. D. or other

Address: Cumberland, Md. Date signed: Dec 25-40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

12235

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 yrs.

Hospital, Institution, or Street address where death occurred: 176 S. Allegany St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 176 S. Allegany St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Bernard Kelley

3.(b) Social Security Number 214-07-0439

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Young

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Sept 15 1887

8. AGE:	Years	Months	Days	If less than one day
	53	3	2	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: District Credit Mgr.

11. Industry or business: Fire Co.

MOTHER FATHER

12. Name: Michael Kelley

13. Birthplace: Mt Savage Md.

MOTHER

14. Maiden name: Sarah Welsh

15. Birthplace: Mt Savage Md.

16. Informant: Wm. B. Kelley Jr.

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 '40 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Dec 19 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 40, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 40 to Dec 17 40

and that I last saw him alive on Dec 17 1940

Immediate cause of death: Leukemia (Lymphatic) — DURATION: Probably 3 or 4 weeks

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: R. N. Trewartha MD

Address: Cumberland Md M. D. or other

Date signed: Dec 18 '40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

12236

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland. Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred: 304 Wallace St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Wallace St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ella Bernatte Kelly

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jno. J. Kelly.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 26. 1867

8. AGE: Years: 73. Months: 2. Days: 1. If less than one day: ..... hrs. ..... min.

9. Birthplace: Barlow, Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own Home.

FATHER

12. Name: Thomas Foster

13. Birthplace: Ireland

MOTHER

14. Maiden name: Margaret Kean Cain

15. Birthplace: Ireland

16. Informant: Frank T. Kelly.

Address: 16 N. Chase St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 (month) 30 (day) 1940 (year)

Cemetery or crematory: St. Peters Cemetery.

Location: Westernport, Md.

18. Funeral director: E. S. Boal

Address: Westernport. Md.

19. Dec 30 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 27, 1940, at 11:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1940, to Dec 27 1940

and that I last saw her alive on Dec 27 1940

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. C. Barnes M.D. (M. D. or other)

Address: Cumberland Md. Date signed 12-28-40

RECEIVED
JAN 7 1941
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

12237

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Western Port
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred: 98 Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 98 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Joseph Kelly

3. (b) Social Security Number

4. Sex: Woman
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) May 30 1856

8. AGE: Years 82 | Months 7 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Dress Maker
11. Industry or business

FATHER
12. Name: Francis Kelly
13. Birthplace: Ireland

MOTHER
14. Maiden name: Sarah Fearon
15. Birthplace: Ireland

16. Informant: Rose Kelly
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 10, 1940 (month) (day) (year)
Cemetery or crematory: St. Gabriels
Location: Barton Md
18. Funeral director: Ellsworth S. Beal
Address: Westernport, Md.
19. Dec. 10 1940 (Date rec'd by registrar) A. Bayenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 1940, at 1245 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1940, to Dec. 7 1940 and that I last saw her alive on Dec. 7 1940

Immediate cause of death: Influenza — DURATION: 1 month
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: P. E. Berry M.D. M. D. or other
Address: Piedmont, Wva. Date signed: Dec. 10-1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

12238

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 123 So. Liberty St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: #5 Roberts Place Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Cumberland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: JOHN HARRY KELSO

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 29, 1894

8. AGE: Years	Months	Days	If less than one day
46	5	25	____ hrs. ____ min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Operated a Garage

11. Industry or business

FATHER
12. Name: Scott Kelso
13. Birthplace: Maryland

MOTHER
14. Maiden name: Minnie Keefer
15. Birthplace: Maryland

16. Informant: George Kelso

Address: R.D. #5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Cumberland, Md.

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. Dec 26 1940 (Date rec'd by registrar) Jos P. Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24, 1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1940, to Dec. 24 1940, and that I last saw h (m) alive on Dec. 24, 1940.

Immediate cause of death	DURATION
angina pectoris	?
Due to	
Coronary disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: D. B. Moore, M.D. M. D. or other

Address: Medical Bldg Date signed: 12/24/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

12239

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred: 724 Bedford Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 724 Bedford Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Theresa Kleinhofer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry A. Kleinhofer

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Oct 28 1875

8. AGE:

Years	Months	Days	If less than one day
65	1	25	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: John Hintermeyer

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Mc Dudley

15. Birthplace: Md.

16. Informant: Henry A. Kleinhofer

Address: Cumberland.

17. Burial, cremation, or removal. Which? Burial Date thereof: Dec 26 40 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Dec 26 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1940 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1940, to Dec 23 1940 and that I last saw her alive on Dec 23 1940

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. C. Bowen M.D. (M. D. or other)

Address: Cumberland Md Date signed: 12-24-40

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 1700

Reg. Dist. No. 7

12240

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Barton, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 50 years

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Barton Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs Anna May Kyle

3 (b) If veteran, name war ✓

3 (c) Social Security No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank Kyles

6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) March 11, 1874

8. AGE: Years 66 Months 9 Days 12 If less than one day ___ hr. ___ min.

9. Birthplace Westernport, Alleg. Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER
12. Name Henry Lee
13. Birthplace England

MOTHER
14. Maiden Name Ellen Foley
15. Birthplace England

16 (a) Informant Mr. Frank Kyles
(b) Address Barton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 1940 (month) (day) (year)

(c) Cemetery or crematory Laurel Hill
Location Mocow, Md.

18 (a) Funeral director Jay Boal Berry
(b) Address Westernport, Md.

19 (a) Dec. 26 (Date rec'd by registrar) (b) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. Date of death Dec 25 1940, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw him alive on ___ 19___.

Immediate cause of death Automobile accident

Due to Struck by automobile

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration Instant Death

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. H. Trevaskis, M.D.
acting Deputy medical Examiner M. D. or other

Address Cumberland, Md Date signed Dec 26-40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

12241

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

WITHIN CORPORATE LIMITS

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 75 Washington

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward McComas Kyle

3.(b) Social Security Number: 216-01-8790

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Gwen Kyle

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Oct 5 - 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	2	5		

9. Birthplace: Baston - alleg - Md. (Town, county, and state)

10. Usual occupation: Laborer W.P.A.

11. Industry or business

FATHER 12. Name: Geo. Kyle

13. Birthplace: Scotland

MOTHER 14. Maiden name: Nettie McIntyre

15. Birthplace: Baston, Md

16. Informant: Geo Kyle

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: J. J. Hunt

Address: Frostburg, Md.

19. 12-12-1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 1940, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Dec 10 1940 and that I last saw h... alive on Dec 9 1940

Immediate cause of death	DURATION
Chronic Myocarditis	3
Due to	1
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed 12-11-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

WITHIN CORPORATE LIMITS

12242

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 286 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Lemmert

3.(b) Social Security Number 214-05-9851

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Jane Lemmert

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 30 - 1872

8. AGE: Years 68 | Months 5 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Frostburg - Alleg - Md.

(Town, county, and state)

10. Usual occupation: Lumber worker

11. Industry or business: Tin plant

FATHER 12. Name: George A. Lemmert

13. Birthplace: Germany

MOTHER 14. Maiden name: Anna Kuenzig

15. Birthplace: Germany

16. Informant: George Lemmert

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. Dec. 28 - 1940 (Date rec'd by registrar) Mrs. A. R. Hosker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1940 at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1940 to Dec 27 1940

and that I last saw h... alive on Dec 27 1940

Immediate cause of death	DURATION
Cancerous occlusion	
Carcinoma of Ileum	
Due to: Adhesions	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Engle M.D.

M. D. or other

Address: 286 E. Main St. Date signed: 12-28-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

12243

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs.

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 FIFTH ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MISS BARBARA LIPPOLD

3.(b) Social Security Number
214-07-2323

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 12 1913

8. AGE: Years	Months	Days	If less than one day
27	5	18	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation CELANESE

11. Industry or business

FATHER
12. Name JOHN LIPPOLD
13. Birthplace AUSTRIA

MOTHER
14. Maiden name TERSA MALETICH
15. Birthplace AUSTRIA

16. Informant Theresa Lippold
Address SELF Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 40 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland.

18. Funeral director Louis Stein & Son.

Address Cumberland

19. Dec 21 19 40 Joseph L. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 20, 1940 19 5:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 th 1940, to Dec. 20 1940 and that I last saw h.er alive on Dec. 20 1940.

Immediate cause of death	DURATION
Abdominal carcinomatosis	6 mos.
origin doubtful	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Retro-peritoneal & gastric carcinoma Date of op. Aug. 14. 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Lanich M.D.
M. D. or other

Address Cumberland Md. Date signed 12-20-40

DR. LANICH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49-A

CERTIFICATE OF DEATH

12244

Reg. Diat. No.

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Isabella Ganse Little

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: Henry Little

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1872

8. AGE: Years	Months	Days	If less than one day
68		17	hrs. min.

9. Birthplace: New York, N.Y. (Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Herrey D. Ganse

13. Birthplace: New York City

MOTHER 14. Maiden name: Emma Wyle

15. Birthplace: Pleasant Valley, N.Y.

16. Informant: Anna Little

Address: 33 Broadway, Frostburg Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 6 1940 (month) (day) (year)

Cemetery or crematory:

Location: Madison, N.J.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. Dec. 6th 1940 (Date rec'd by registrar) mrs. A.R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 1940, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1940, to Dec 4 1940

and that I last saw h[illegible] alive on Dec 4 1940

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to Metastasis to	
Due to Lungs & liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C.M. Ruckman M. D. or other

Address: Lee Wrenn Date signed: 12-5-40

Dr. Earl

RECEIVED
JAN 3 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12245

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 122 So Centre St.
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 122 So Centre St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Marion Gertrude Litton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov 23 - 1940

8. AGE: Years | Months: 1 | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Leroy Litton
13. Birthplace: Md.

MOTHER — 14. Maiden name: Gertrude Shipley
15. Birthplace: Md

16. Informant: Leroy Litton - father
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 9 - 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: V. L. Lamberson
Address: Cumberland, Md.

19. Dec. 9 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1940 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1940 to Dec 7 1940 and that I last saw h[illegible] alive on Dec 7 1940

Immediate cause of death: Pleo colitis — DURATION: about Dec 1

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: M. D. Williams M. D. or other
Address: 133 Va Date signed 12/11/40

Authorization to change date of birth - birth certificate -

1/14/41/M. S.

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

12246

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Railroad Street

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 43 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Railroad

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Marion M. D. Loar

3. (b) Social Security Number: —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband or wife: John R. Loar

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1876

8. AGE:

Years	Months	Days	If less than one day
64	10	8	____ hrs. ____ min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Engle Smith

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Elizabeth McDonald

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. Wm. M. Long

Address: Midland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 25, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Dec. 25 1940 (Date rec'd by registrar) E. Owen Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1940, at —M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on December 23, 1940 to only 19—, and that I last saw h—r alive on December 23 1940.

Immediate cause of death	Central Hemorrhage	DURATION
Due to		
Due to		
Other conditions	Hypertension	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M. D.

M. D. or other

Address: Midland, Md Date signed 12-24-40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12247

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town RAWLINGS Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. MARGARET MAIN

3. (b) Social Security Number None

4. Sex: FEMALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: JOHN MAIN (DECEASED)

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 9, 1855

8. AGE: Years 85 | Months 6 | Days 24 | If less than one day ____ hrs. ____ min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: AT HOME

11. Industry or business

FATHER 12. Name: ELITZ, HENRY

13. Birthplace: GERMANY

MOTHER 14. Maiden name: HORICE, MARY

15. Birthplace: GERMANY

16. Informant: MRS. JAMES KEMPHER

Address: KEYSER, W.VA.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 5, 1940 (month) (day) (year)

Cemetery or crematory: QUEENS POINT CEMETARY

Location: KEYSER, W.VA.

18. Funeral director: J.H. Markwood Sons

Address: Keyser W. Va.

19. Dec 5 1940 (Date rec'd by registrar) Jos. P. Franklin MD Registrar

MEDICAL CERTIFICATION 7:45P

20. DATE OF DEATH DECEMBER 3 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-28-1940 to 12-3-1940 and that I last saw h[illegible] alive on 12-3-1940.

Immediate cause of death: Diabetic Gangrene

Due to: Diabetes Mellitus — DURATION: 7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams M. D. or other

Address Cumberland Date signed 12-5-40

F. WILSON & W.F. WILLIAMS

RECEIVED
JAN 7 1941
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

12248

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred: Railroad Street

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Railroad Street
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: Susan M. Anderson Marshall

3. (b) Social Security Number: –

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jesse Dolan Marshall

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): May 19, 1865

8. AGE: Years 75 | Months 7 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Flintstone Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Elias Anderson
13. Birthplace: Unknown

MOTHER
14. Maiden name: — Snyder
15. Birthplace: Unknown

16. Informant: Mr. Jos. Wm. Jones

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1940 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Inkerman, W. Va.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Dec. 30 40 (Date rec'd by registrar) E. Fox Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1940, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1940, to December 29 1940 and that I last saw her alive on December 28 1940

Immediate cause of death: Coronary Occlusion

DURATION

Due to:

Due to:

Other conditions: Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ann Shelton Jr. M.D. (M. D. or other)

Address: Midland, Md. Date signed: 12-30-40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

12249

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: 356 Williams St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 356 Williams St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Delbert Raymond McCoy

3.(b) Social Security Number 214-07-5986

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lorraine Kreger McCoy

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): June 21, 1914

8. AGE: Years: 26 | Months: 5 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Silk Mill

FATHER — 12. Name: Hugh D. McCoy

13. Birthplace: Madley, Pa.

MOTHER — 14. Maiden name: Gertrude Miller

15. Birthplace: Bedford Valley, Pa.

16. Informant: Lorraine McCoy

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 3, 1940 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Centerville, Pa.

18. Funeral director: Joseph Hafer

Address: 730 Baltimore Ave, Cumberland, Md

19. Dec 3 1940 (Date rec'd by registrar) J. P. Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1940, at 2:35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 1940, to Dec 1st 1940

and that I last saw h... alive on Dec 1st 1940

Immediate cause of death	DURATION
Bronchopneumonia	2 wks.
Due to	
Due to	
Other conditions: Acute cardiac dilatation	3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Lapper M. D. or other

Address: Lyndman, Pa. Date signed: 12/2/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

12259

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Frostburg Hospital
Stay in hospital or inst. (yrs., or mos., or days): minors
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md. County: Garrett
City or town: farm House Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ROBERT - MEESE

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife: Mary Albright - Meese
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 28 1893

8. AGE:

Years	Months	Days	If less than one day
47	8	15	hrs. min.

9. Birthplace: Somerset Co. Penna.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Daniel D. Meese
13. Birthplace: Somerset Co. Penna.

MOTHER
14. Maiden name: Mary Hall Miller
15. Birthplace: Pennsylvania

16. Informant: (Undertaker) S. M. Thomas
Address: Salisbury, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 (month) 13 (day) 1940 (year)
Cemetery or crematory: Galleville Church Cemetery
Location: Galleville P.O. Somerset Co Pa

18. Funeral director: Stanley M Thomas
Address: Salisbury Penna

19. Dec 16 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 1940, at 4:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1940, to Dec 10 1940, and that I last saw him alive on Dec 10 1940

Immediate cause of death	DURATION
Cerebral Embolism	2 Days
Due to Pulmonary Embolism	10 Days
Due to Acute Appendicitis	26 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Gente Gangrenous Appendicitis
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. O. McCaney M.D. M. D. or other
Address: Frostburg Md. Date signed Dec 10 1940

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Decatur St (If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: John Morris

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Martha "DeVore" Morris

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): July 18, 1863

8. AGE: Years: 77 Months: 5 Days: 1 If less than one day: ..... hrs. ..... min.

8. Birthplace: Everett Pa (Town, county, and state)

10. Usual occupation: Transfer Man

11. Industry or business: Own Business

FATHER

12. Name: James R Morris

13. Birthplace: Everett Pa

MOTHER

14. Maiden name: Not Known

15. Birthplace: Not Known

16. Informant: Mrs. Florence White

Address: Dexter Place Cum. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21, 1940 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran Cem.

Location: Cumberland Md

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. Dec 21 1940 (Date rec'd by registrar) Joseph Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-19-1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 22 1940, to Dec. 19 1940 and that I last saw him alive on Dec 18, 1940

Immediate cause of death: Arterio Sclerosis — DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other

Address: Cumberland Date signed: 12/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

12252

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, Institution, or street address where death occurred:
510 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 510 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Tobias Mountain

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louisa Ellin

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Jan 20 1859

8. AGE: Years	Months	Days	If less than one day
81	10	13	hrs. min.

9. Birthplace: Mouse Township Bedford, Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Truck Farming

FATHER 12. Name: Aaron Mountain

13. Birthplace: Hollidaysburg, Pa.

MOTHER 14. Maiden name: Eva Ann O'Neil

15. Birthplace: Uniontown

16. Informant: Mrs. Tobias Mountain

Address: 510 Baltimore Ave-Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 6, 1940 (month) (day) (year)

Cemetery or crematory: Pleasant Grove

Location: Baltimore Pike-Cumberland Md

19. Funeral director: Jacob Haller

Address: Cumberland Md.

19. Dec. 6 (Date rec'd by registrar) 19 40 Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3rd 40 19 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 40 19 to Dec 3 40 19 and that I last saw h.. alive on Dec 1 40 19

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs.
Due to	
Due to	
Other conditions: Arteriasclerosis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. R. Iwaskis M.D.
M. D. or other

Address: Cumberland md Date signed: Dec 5-'40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12253

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
340 Virginia, Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 340 Va. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John T. Murphy Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1939

8. AGE: Years	Months	Days	If less than one day
I	0	24	..... hrs. ..... min.

9. Birthplace: Cumberland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John T. Murphy
13. Birthplace: Martinsburg, West, Va.

MOTHER — 14. Maiden name: Geneive Johnson
15. Birthplace: Davis, West, Va.

16. Informant: John T. Murphy
Address: 340 Va. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec (month) 17 (day) 1940 (year)
Cemetery or crematory: Hillcrest
Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. Dec. 17 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. By Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1940 at 10:10 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 1940 to Dec 14 1940 and that I last saw h[illegible] alive on Dec 14 1940

Immediate cause of death	DURATION
Enteric Colitis	6 dys
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 133 Va Ave Date Signed: 10/31/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

12254

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Crook Neff

3.(b) Social Security Number: none

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Jass Beania Neff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 21 - 1864

8. AGE: Years: 76 Months: 7 Days: 25 If less than one day ..... hrs. ..... min.

9. Birthplace: Morgantown, W. Va. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Grocery man

FATHER
12. Name: Thomas W. Neff
13. Birthplace: Eckhart, Md.

MOTHER
14. Maiden name: Lavinia Roantz
15. Birthplace: Md.

16. Informant: Mrs John Zentmyer

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19-1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Dec. 17 1940 (Date rec'd by registrar) R. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1940 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 1940 to Dec. 16 1940 and that I last saw him alive on December 13 1940

Immediate cause of death: Chronic Myocardial Degeneration — DURATION: over 5 yrs

Due to: General Arteriosclerosis — over 10 yrs

Due to: age

Other conditions: Carcinoma of liver.

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: William C. Harrison MD (M. D. or other)

Address: Mount Savage Md. Date signed: 12/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M-a)

CERTIFICATE OF DEATH

12255

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 21 days.

Stay in this community (yrs., or mos., or days) 25 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 5 Mt. Vernon Pl.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alice Victoria Newberry

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William D. Newberry

6(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 8/7/1893

8. AGE: Years	Months	Days	If less than one day
47	3	29	hrs. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER 12. Name Jacob Remmert

FATHER 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Elizabeth Arthur

MOTHER 15. Birthplace W. Va.

16. Informant William D. Newberry

Address 919 N Allegany St

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 9, 1940 (month) (day) (year)

Cemetery or crematory Linden Park

Location Frederick Rd - Balto

18. Funeral director V. L. Lemmerman

Address Cumberland Md

19. Dec 9 1940 Jos. P. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1940, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1940, to Dec 6 1940, and that I last saw h alive on Dec 1 1940.

	DURATION
Immediate cause of death: Final coma severe Pat level of 69 cm mercury	
Due to Vertebra	30 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov 6, 1940

Where did injury occur? Cumberland Allegany Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fell 6 feet Injured at work? no

23. SIGNATURE F. M. Wilson Jr. M. D. or other

Address Cumberland Md Date signed Dec 6 1940

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

12256

WITHIN CORPORATE LIMITS.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 215 Race St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 215 Race St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna M. Norwood

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Edward Norwood
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 7 1849

8. AGE: Years 91 | Months 5 | Days 11 | If less than one day ... hrs. ... min.

8. Birthplace: Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER
12. Name: Jacob Leighter
13. Birthplace: Md.
MOTHER
14. Maiden name: Unknown.
15. Birthplace:
16. Informant: Mrs Mary Elizabeth Cruthers
Address: Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21.40 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc
Address: Cumberland. Md.
19. Dec 21 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1940, at 7:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1940, to Dec 19 1940 and that I last saw her alive on Dec 19 1940
Immediate cause of death: arterio sclerosis
Due to: age
Due to:
Other conditions:
(Include pregnancy within 8 months of death)

DURATION
5 yrs

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: M Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M S B Owens M. D. or other
Address: 33 Va Date signed: 12/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9428)

CERTIFICATE OF DEATH

12257

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 785 Fayette Ste.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 785 Fayette St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Peskino

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Philip Peskin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10, 1872

8. AGE: Years	Months	Days	If less than one day
68	9	8	hrs. min.

9. Birthplace Cleveland Ohio
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Joseph Peske
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Lawrence Peskin
Address 785 Fayette St
17. Burial Date thereof Dec 19 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Cleveland Ohio
18. Funeral director Davis Stein Inc
Address Cumberland Md
19. Dec. 18 1940 Jos. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1940, at 8:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 1940, to December 18 1940
and that I last saw her alive on December 17 1940

Immediate cause of death	DURATION
Coronary Occlusion	8 weeks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Anderson M.D.
M. D. or other
Address 119 Bedford Date signed 12/19/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

122589

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days): 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Alleg.
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 92 Mt Pleasant St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Baby Ream

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: —

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 10, 1940.

8. AGE: Years: | Months: | Days: 1 | If less than one day: 1 hrs. ____ min.

9. Birthplace: Frostburg (Town, county, and state) Md.

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Raymond Charles Ream
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Winona Ada Rosenberger
15. Birthplace: Garrett Co.

16. Informant: Mrs. Raymond Ream
Address: Frostburg, Md.

17. (Burial, cremation, or removal. Which?) Date thereof Dec. 11 '40 (month) (day) (year)
Cemetery or crematory: Home Lot.
Location: Frostburg, Md.

18. Funeral director: Raymond Ream, Father
Address: Frostburg, Md.

19. Dec. 11th 1940 mo. A.R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1940, to Dec. 11 1940, and that I last saw h-r alive on Dec. 11 1940.

	DURATION
Immediate cause of death	
Prematurity 6½ months.	1 day.
Due to Wt. 3 lbs. 2 oz.	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ____ Injured at work?

23. SIGNATURE: M.E. Gattens M. D. or other
Address: Frostburg, Md. Date signed 12/16/40.

RECEIVED
JAN 3 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

CERTIFICATE OF DEATH

12259

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans, (Rural near) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Betty Irene Robertson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: —years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1940

8. AGE:

Years	Months	Days	If less than one day
	2	19	—hrs. —min.

9. Birthplace: Amberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Charles J. Robertson
13. Birthplace: Town Hill, Md.

MOTHER
14. Maiden name: Elizabeth Rose Beckley
15. Birthplace: Lonaconing, Md.

16. Informant: Charles J. Robertson
Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1940 (month) (day) (year)

Cemetery or crematory: Green Ridge Cemetery

Location: Oldtown, R.F.D.

18. Funeral director: Walter Hawaroth

Address: Paw Paw, W. Va. R. 1

19. Dec 17 1940 (Date rec'd by registrar) Mrs. C. A. Shonholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1940, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1940 to Dec. 16 1940, and that I last saw her alive on Dec. 9, 1940.

Immediate cause of death	DURATION
Rickets	from birth
Due to Premature birth	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other

Address: Little Orleans Md. Date signed: Dec. 16, 1940

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

12260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FLINTSTONE (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. RALPH ROBINETTE

3.(b) Social Security Number 213-12-9755

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CLARA STEINSTORFER

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1898

8. AGE: Years	Months	Days	If less than one day
42	5	23	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation W. P. A. WORKER

11. Industry or business

FATHER 12. Name HARRY O. ROBINETTE

13. Birthplace PA

MOTHER 14. Maiden name BESSIE MAE HARTSOCK

15. Birthplace MD

16. Informant Mrs. Clara Robinette

Address Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 1, 1940 (month) (day) (year)

Cemetery or crematory Robinette Cemetery

Location Baltimore Pike

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Dec 30 19 40 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 8:45 P. M

20. DATE OF DEATH DECEMBER 29 19 40 @ at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 19 40 to Dec 29 19 40

and that I last saw h alive on Dec 29-40 19

Immediate cause of death	DURATION
Cerebral embolism	
Due to Ruptured gastric ulcer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured gastric ulcer Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Gracie M. D. or other

Address Cumberland Md Date signed Dec 30-40

DR. GRACIE

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

12261

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 82 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Margaret J. Ross

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sampson S. Rose

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1857

8. AGE: Years: 82 Months: 11 Days: 14 If less than one day: — hrs. — min.

9. Birthplace: Barton, Allegany Co, Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER

12. Name: William Ayers

13. Birthplace: Lonaconing, Md.

MOTHER

14. Maiden name: Catherine Geary

15. Birthplace: Mt. Savage, Md.

16. Informant: Howard Ross

Address: Barton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Md

18. Funeral director: H. Eichhorn

Address: Lonaconing, Md.

19. Dec 16 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1940, at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1940, to Dec 14 1940, and that I last saw her alive on Dec 14 1940.

	DURATION
Immediate cause of death: Chronic myocarditis	Feb. 1940
Interstitial Nephritis	July 1940
Due to: arteriosclerosis	5 yrs.
Due to: —	—
Other conditions: Cataracts	2 yrs

(Include pregnancy within 3 months of death)

Major findings:

Dt operations: none

Dt autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE P E Berry M. D.

M. D. or other

Address Piedmont W. Va Date signed 12/14/40

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

12262

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Barton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nellie Ellen Shubert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Shubert

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Feb. 5. 1872

8. AGE:

Years	Months	Days	If less than one day
68	10	25	..... hrs. ..... min.

9. Birthplace: Westernport, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: Henry Lee

13. Birthplace: England

MOTHER

14. Maiden name: Ellen Foley

15. Birthplace: England

16. Informant: Mrs. Frank Magruder

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 1 1941 (month) (day) (year)

Cemetery or crematory: Dawes Hill Cemetery

Location: Moscow, Md.

18. Funeral director: E. S. Boal

Address: Westernport, Md.

19. Dec 31 1940 (Date rec'd by registrar) S. A. Bouchat Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1940, at 3:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1940, to Dec 30 1940

and that I last saw h alive on April 1940

Immediate cause of death: Acute Myocardial failure — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reese, M.D. M. D. or other

Address: Westernport Md. Date signed 12-31-40

RECEIVED
JAN 6 1941
BUREAU V.S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Make 2 punch cards Stillborn twins

Reg. Dist. No. 12263 12264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 326 Furance Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Stillborn Silvions

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 19, 1940

8. AGE:

Years	Months	Days	If less than one day
Stillbirth			..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Carroll Theodore Silvions

13. Birthplace: Grantsville Md.

MOTHER

14. Maiden name: Opal Mertie Amick

15. Birthplace: Oldtown, Maryland

16. Informant: [redacted] Silvions

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23 '40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Stein & Son

Address: Cumberland

19. Dec 21 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from At birth 19..., to ... 19...

and that I last saw h ... alive on ... 19...

Immediate cause of death	DURATION
Still Born	
Due to: Mother fell Nov 22nd 1940	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R. C. Bowen M.D. (M. D. or other)

Address ..... Date signed

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-8)

12265

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: 221½ Oak St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221½ Oak St
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Edward Sherman Smith

3. (b) Social Security Number 217-10-1837

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary F

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Oct 19 1878

8. AGE: Years 62 | Months 1 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: Green Ridge Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Celanese Corp.

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Sarah Smith
15. Birthplace: Pa.

16. Informant: Harry Smith
Address: Rt. #3 Bedford Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 12 '40 (month) (day) (year)

Cemetery or crematory: Mamro Advice Pa.

Location: " " "

18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.

19. Dec 12 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1940, at 8 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1940, to Dec 9 1940 and that I last saw him alive on Dec 9 1940

Immediate cause of death: Carcinoma. Lower Jaw

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: About 1 yr

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury Injured at work?

23. SIGNATURE: M. B. Owen M. D. or other

Address: 133 Va Ave Date signed: 10/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-31)

CERTIFICATE OF DEATH

12266

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Row

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Edward Snelson

3.(b) Social Security Number: 215-10-1284

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Florence Snelson

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 28 - 1881

8. AGE: Years: 59 Months: 4 Days: 6 If less than one day: hrs. min.

9. Birthplace: Stafford Shire England (Town, county, and state)

10. Usual occupation: watchman

11. Industry or business: Boatyard

FATHER — 12. Name: John Snelson

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Harriet Stiffen

MOTHER — 15. Birthplace: England

18. Informant: Mrs Florence Snelson

Address: Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5-1940 (month) (day) (year)

Cemetery or crematory: St George

Location: Mt Savage Md.

18. Funeral director: J. J. Deal

Address: Frostburg Md

19. Dec 3 1940 (Date rec'd by registrar) H. J. Boyette M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1940 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940 to December 1940

and that I last saw him alive on December 1 1940

Immediate cause of death: Chronic Myocardial Degeneration. — DURATION: 1 yr +

Due to: Carcinoma of liver and lung. — DURATION: 1 yr. +

Due to:

Other conditions: General Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Harrison M. D. (M. D. or other)

Address: Mount Savage Date signed: 12/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

12267

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122-a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)

Street No. Spruce St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. MARY STEINLA

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife JACOB STEINLA (DECEASED)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 13 1855

8. AGE:

Years	Months	Days	If less than one day
84	11	19	..... hrs. ..... min.

9. Birthplace ~~MARYLAND~~ Meyersdale, Somerset, Pa
(Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business at Home

FATHER
12. Name FREDERICK WARNER (DECEASED)
13. Birthplace Germany

MOTHER
14. Maiden name BARBARA Deist (DECEASED)
15. Birthplace Germany

16. Informant Irvin Steinla
Address 133 S. Mechanic St - Cumberland

17. Burial Date thereof Dec 5, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenville

Location Pocahontas Pa.

18. Funeral director Jacob Hafer
Address Cumberland Md.

19. Dec 5 1940 Jos. P. Franklin M.D.
(Date rec'd by registrar) M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 2 1940 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1940, to Dec 2 1940 and that I last saw her alive on Dec 2 1940

Immediate cause of death Strangulated femoral Hernia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations Strangulated bowel gangrenous Date of op. 11/26/40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Enfield M. D. or other

Address Cumberland Date signed 12/3/40

DR. ENFIELD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-B

CERTIFICATE OF DEATH

12268

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
508 Greene St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 508 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Virginia Stephens

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Henry Stephens
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 6 1883

8. AGE: Years	Months	Days	If less than one day
57	10	21	hrs. min.

9. Birthplace Williamsport W. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name of father Wm H Bruce.
13. Birthplace of father W. Va.
14. Maiden name of mother Rachel Steward
15. Birthplace of mother W. Va.
16. Informant Henry Stephens
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. Dec 30 40 (Date rec'd by registrar) Joe L Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1940, to Dec 27 1940 and that I last saw her alive on Dec 27 1940

Immediate cause of death	DURATION
Carcinoma of stomach	1 1/2 yr.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Cyrle B. Everhart M.D. M. D. or other
Address 36 Greene Street Cumberland, Md. Date signed 12/27/40

RECEIVED
JAN 7 1941
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

12269

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Spring Gap Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:—

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Spring Gap Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Stillborn Boy Twigg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Stillborn

6.(b) Name of husband or wife.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1940

8. AGE:

Years	Months	Days	If less than one day
			.....hrs. .....min.

9. Birthplace Spring Gap Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name Norman Twigg

13. Birthplace Oldtown Md

MOTHER 14. Maiden name Marie Stallings

15. Birthplace Spring Gap, Md

16. Informant Marie Twigg

Address Spring Gap Md

17. Burial Date thereof Dec 25 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Spring Gap, Md

18. Funeral director Jacob Zofer

Address Cumberland, Md

19. Dec 26 1940 Jos. P. Franklin M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1940, at 2.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 1940, to Dec. 24 1940

and that I last saw h.....alive on .....19.....

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions Hydramnios, Hypertrophy of Bladder	

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. M. Schindler 2nd M. D. or other

Address 41 Greene St. Date signed Dec. 24/1940

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12270

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Allegany
City or town: Rural - Oldtown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Rural - Oldtown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Wm. Bruce Twigg

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Martha C. Hite
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.): Oct. 14, 1870

8. AGE: Years 70 | Months 1 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Oldtown, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: General Farming.
FATHER
12. Name: Wm. D. Twigg
13. Birthplace: Oldtown, Md.
MOTHER
14. Maiden name: Mildred Ann Springstead
15. Birthplace: Oldtown, Md.
16. Informant: Mrs Agnes Galliher
Address: Little Orleans, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10, 1940 (month) (day) (year)
Cemetery or crematory: Oliver Grove
Location: Near Oldtown, Md
18. Funeral director: Jacob Hafer
Address: Cumberland, Md.
19. Dec 9 1940 (Date rec'd by registrar) Mrs C.A. Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1940, at 10:30 pm M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1940, to Dec 7 1940
and that I last saw him alive on Dec 5 1940
Immediate cause of death: Central apoplexy
Due to: Arteriosclerosis
Due to: .....
Other conditions: .....
(Include pregnancy within 3 months of death)

DURATION: about 2 yrs.

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: NS Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE: M E B Owens M. D. or other
Address: 133 Va Ave Date signed: 12/9/40

M. E. B. Owens

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

12271

Reg. Diat. No. 4

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 3 hrs 50 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oldtown

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Baby Girl Unger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Newborn.

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12-11-40

8. AGE: Years	Months	Days	If less than one day
-			7 hrs. 50 min.

9. Birthplace: Allegany County (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Harold Richard Unger

FATHER 13. Birthplace: Gray Cape, West Virginia

MOTHER 14. Maiden name: Elsie Katherine Queen Forth

MOTHER 15. Birthplace: Lowdale, West Virginia

16. Informant: Harold Unger

Address: Oldtown Route #1

17. Cremation (Burial, cremation, or removal, which?) Date thereof: Dec. 12 1940 (month) (day) (year)

Cemetery or crematory: Hafer's

Location: Cumberland

18. Funeral director: Jacob Hafer

Address: Cumberland, Md

19. Dec 13 1940 (Date rec'd by registrar) Jos. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1940, at 2 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 1940, to Dec 11 1940 and that I last saw her alive on Dec 11 1940

Immediate cause of death	DURATION
Prematurity (32 wks gestation)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur J. Jones M.D. M. D. or other

Address: 402 Liberty St. Date signed: 12-12-40

D Arthur Jones

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

12272

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 332 Central Ave

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 332 Central Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Anna C. Washington

3. (b) Social Security Number none

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of ~~husband~~ or wife Late Henry Washington

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 22 —

8. AGE: Years 85 Months Days If less than one day hrs. min.

9. Birthplace West Va (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name John W. —

13. Birthplace Va

MOTHER 14. Maiden name Mary Knight

15. Birthplace Va

16. Informant Mrs Sadie Barton

Address Pittsburgh, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8/40 (month) (day) (year)

Cemetery or crematory Summer Cemetery

Location Cumberland, Md

18. Funeral director V. L. Lemberger

Address Cumberland, Md.

19. Dec 9 1940 (Date rec'd by registrar) Jos P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1940, at 12:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 11, 1940, to Dec 5 1940, and that I last saw her alive on Dec. 4, 1940.

Immediate cause of death	DURATION
Edema of Lungs	One day
Due to Acute Bronchitis	4 weeks
Due to	
Other conditions Arteriosclerosis	10 years
Chronic Interstitial Nephritis	5 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Hollomand M.D. M. D. or other

Address 145 Hanover St Date signed 12-5-40

RECEIVED
JAN 7 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-20)

12273

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 537 Columbia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Charles Joseph Welsh.

3. (b) Social Security Number None.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

8.(b) Name of husband or wife: Anna Lavin

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov 27 1862

8. AGE: Years 78 | Months — | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Ry. Conductor Retired 5 yrs.

11. Industry or business

FATHER
12. Name: Patrick Welsh.
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Mary Inrow
15. Birthplace: Ireland.

16. Informant: Charles Welsh.
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28 40 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. Dec 27 1940 Jos P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1940 at 7 45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1940, to Dec. 26 1940 and that I last saw h.. alive on Dec. 25 1940

Immediate cause of death	DURATION
Chronic Nephritis.	1939
Due to Arterio Sclerosis	1935
Benign Hypertrophy of Prostate	1930
Due to Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. W. Eleason M.D.
M. D. or other

Address: 126 Union St. Cumberland Md. Date signed 12/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 7 1941
BUREAU V. S.

12274

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Offutt St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. John H. Welsh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ida Belle Rice

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) August 11, 1858

8. AGE: Years	Months	Days	If less than one day
82	3	20	hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name John Welsh
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Not Known?
15. Birthplace ?

16. Informant Mrs. Glady Karnes

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/40 (month) (day) (year)

Cemetery or crematory Mts. Plesant Cemetery

Location Cumberland Md.

18. Funeral director Harvey H. Ziegler

Address Hyndman Pennsylvania

19. 12-2-40 19 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1940, at 3:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. 11-27-1940 to 12-1-1940 and that I last saw him alive on 11-30-1940.

Immediate cause of death	DURATION
Arterio sclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 12-1-40

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

12275

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County Allegany
City or town Flintstone Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Boone St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Virginia "Rose" Whip
3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Henry Whip
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug 5, 1859

8. AGE: Years 81 Months 3 Days 26 If less than one day ... hrs. ... min.

9. Birthplace Bedford Valley - Bedford - Pa
(Town, county, and state)
10. Usual occupation House work
11. Industry or business At Home
FATHER
12. Name Henry Rose
13. Birthplace Bedford Valley, Pa
MOTHER
14. Maiden name Talitha Ash
15. Birthplace Bedford Valley, Pa
16. Informant Homer D. Whip
Address Flintstone, Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 3, 1940 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Manns Choice Pa
18. Funeral director Jacob Hofer
Address Cumberland, Md.
19. Dec 3 1940 (Date rec'd by registrar) D. Bennett Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Decembr 1 1940, at 8P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Dec 1940
and that I last saw in ... alive on Nov. 30 1940
Immediate cause of death Arterio sclerosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
DURATION 4 yrs
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide W Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE M E B Owens M. D. or other
Address 133 Va Ave Date signed Dec 1940

M E B. Owens

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V.S.

THIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-e)

12276

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Queen City Restaurant at B & O Station

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pa County Allegheny

City or town Millvale Pa Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No 149 West McIntyre St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Albert Wilson

3. (b) Social Security Number 705-09-4264

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth Simon

6(c) ✗ alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 5 ~~1900~~ 1891

8. AGE: Years 40 Months 10 Days 9 If less than one day ____ hrs. ____ min.

9. Birthplace Pa (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Balto & Ohio R R

FATHER 12. Name John Wilson

13. Birthplace U S A

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Albert Fressler R F # 4

Address Evergreen Rd Millvale Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10 1940 (month) (day) (year)

Cemetery or crematory Voettly Cemetery

Location Millvale Pa

18. Funeral director Gavin Stein Inc

Address Cumberland Md

19. Dec 14 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1940, at 4 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death This man fell from a stool in restaurant dead

Due to Organic Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Koon M. D. or other

Address Cumberland Md Date signed 12/14/40

RECEIVED
DEC 27 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

12277

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred: 532 Greene St

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 532 Greene St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Virginia Wilson

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jesme P Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 11, 1862

8. AGE: Years 78 | Months 7 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Hall
13. Birthplace: Md.

MOTHER
14. Maiden name: Messera
15. Birthplace: ?

16. Informant: Mrs Florence Denson

Address: 532 Greene St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1940 (month) (day) (year)

Cemetery or crematory: Summer

Location: Cumberland, Md

18. Funeral director: Louis Steyr Eng.

Address: Cumberland, Md

19. Dec 26 1940 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1940, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1940, to Dec 23, 1940 and that I last saw her alive on Dec 22, 1940

	DURATION
Immediate cause of death: Edema of the Lungs	One day
Due to: Arteriosclerosis	10 yrs.
Due to: Chronic interstitial nephritis	15 yrs
Other conditions: Secondary anemia	1 month

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C. Hollomon M.D. M. D. or other

Address: 148 Hanover Date signed: Dec 23 '40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (59-C) Reg. Dist. No. 2

CERTIFICATE OF DEATH

12278

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Flintstone
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Star Delivery
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Flintstone
(If outside city or town limits, write RURAL and give town)
(d) Street No. Star Delivery
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Matilda Agnes Wilson

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Argyle Wilson

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1869

8. AGE: Years	Months	Days	If less than one day
71	1	9	____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Twigg
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Harrwood
15. Birthplace Maryland

16 (a) Informant Mrs. Marie Hartung
(b) Address Flintstone, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1940 (month) (day) (year)
(c) Cemetery or crematory Wilson Cem.
Location On Town Creek

18 (a) Funeral director J. C. Wolford
(b) Address Cumberland, Md.

19 (a) Dec. 4 (Date rec'd by registrar) (b) D. Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 2, 1940, at Flintstone Md.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1939, to Nov. 30 1940, and that I last saw her alive on Nov. 30 1940.

Immediate cause of death	Duration
Chronic Rheumatism Osteoarthritis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Twigg Jr. M. D. or other
Address Flintstone Date signed Dec. 3-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 3 1941
BUREAU V. S.

12279

STATE OF MARYLAND—CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

107

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 425 Chesnut St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME George Windermuth

(a) Residence: No. 425 Chesnut St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilhemmia Burkett

6. DATE OF BIRTH (month, day, and year): March 20 1855

7. AGE: Years 85 | Months 8 | Days 25 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Machinist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: R. R.

10. Date deceased last worked at this occupation (month and year): Retired 16 yrs.

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Cumberland Md.

FATHER

13. NAME: Nicholas Windermuth

14. BIRTHPLACE (city or town) (State or country): Germany.

MOTHER

15. MAIDEN NAME: Anna M. Kaylor

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT (Address): George Windermuth Cumberland

18. BURIAL, CREMATION, OR REMOVAL

Place: Greenmount Cem. Date: Dec 18, 1940

19. UNDERTAKER (Address): Louis Stein Inc Cumberland

20. FILED: Dec 18, 1940 Joseph P. Franklin M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec 15, (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1940, to Dec 15, 1940

I last saw him alive on Dec 15, 1940; death is said to have occurred on the date stated above, at 8 30 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	2 days

Other Contributory Causes of importance:

Uremia	?

Name of operation Date of

What test confirmed diagnosis? Physical Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. R. Hodges, Jr. M. D.

(Address) Cumberland, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

RECEIVED JAN 7 1941 BUREAU V. S.

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (95-C)

Reg. Dist. No. 7

12280

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Barton (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Main

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Barton (If outside city or town limits, write RURAL and give town)

(d) Street No. Main (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Joseph Winkler

3 (b) If veteran, name war —

3 (c) Social Security No. 220-10-2292

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 5 1876

8. AGE: Years 64 Months 8 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace Barton - Allegany - Md. (Town, county, and state)

10. Usual occupation W. P. A. Laborer

11. Industry or business

FATHER 12. Name George Winkler

13. Birthplace Germany

MOTHER 14. Maiden Name Rosina Hoking

15. Birthplace Germany

16 (a) Informant Edward Winkler

(b) Address Barton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1940 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St. Gabriels

Location Barton, Md.

18 (a) Funeral director D. S. Boal

(b) Address Barton Md.

19 (a) Dec 23 (Date rec'd by registrar) (b) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. Date of death Dec 22 1940, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on Dec 21 1940.

Immediate cause of death Probably heart attack was found dead in bed

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. A. Boucher M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

12281

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, Institution, or street address where death occurred: Winchester Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Winchester Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Frances Starbey Winter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Elijah Winter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 27, 1855

8. AGE: Years: 85 | Months: 2 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Romney, Hampshire, W. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Frederick Starbey

13. Birthplace: Romney W. Va.

MOTHER

14. Maiden name: Susan Yates

15. Birthplace: Romney W. Va.

16. Informant: Wressell O. Winter

Address: Cresaptown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3, 1941 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland Md

18. Funeral director: Jacob Hofer

Address: Cumberland Md.

19. Jan 1, 1941 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1940, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to Dec 30 1940

and that I last saw her alive on Dec 27 1940

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 Days
Due to: Cerebral Hemorrhage	1 Yr.
Due to: Chronic Nephritis	1½ Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. H. Koon M. D. or other

Address: Cumberland Md Date signed: 12/30/40

RECEIVED
JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12283

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. #37 BROWNING ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
WOLFORD, HARRY F. MR.

3.(b) Social Security Number
705-69-9464

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: GRACE BUCY
6.(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): Oct. 22 1902

8. AGE: Years: 40 Months: Days: 27 If less than one day: hrs. min.

9. Birthplace: MARYLAND Fossilville Pa
(Town, county, and state)
10. Usual occupation: MACHINIST HELPER
11. Industry or business: B&O R.R.

FATHER
12. Name: CHARLES WOLFORD
13. Birthplace: PA.

MOTHER
14. Maiden name: MOLLIE LEYDIG
15. Birthplace: PA.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND? MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/40 (month) (day) (year)
Cemetery or crematory: Madley
Location: Madley Pa
18. Funeral director: MR. ZEIGLER,
Address: HYNDMAN, PA.

19. Dec 15 1940 (Date rec'd by registrar) Joseph P. Brankley Registrar

DR. LANICH

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1940 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1940 to Dec 15 1940 and that I last saw him alive on Dec 15 1940.

	DURATION
Immediate cause of death: Meningitis Pneumococcus	3 days
Due to: La Grippe	1 week
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. D. Lanich M. D. or other
Address: Cumberland Md. Date signed: 12-15-40

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JAN 7 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

12282

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 hours

Hospital, institution, or street address where death occurred: Reeves Clinic Westernport, Md

How long in hospital or institution? 30 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland (If outside city or town limits, write RURAL and give nearest town)

Street No. ✓ (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: Mary Ann Keating Woods

3. (b) Social Security Number: ✓

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Patrick Woods

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1859

8. AGE: Years 81 | Months 8 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Home

FATHER
12. Name: Bernard Keating
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Coleman
15. Birthplace: Ireland

16. Informant: Terrence Woods

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28, 1940 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec. 26 1940 (Date rec'd by registrar) A. Gazinbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26, 1940, at 6:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25th, 1940, to Dec 26 1940 and that I last saw her alive on Dec 26 1940

Immediate cause of death	DURATION
La Grippe	12-24-40
Bronchial pneumonia	12-25-40
Due to: Chronic myocarditis	—
Due to: Hypertension	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Thorman Reeves, M.D. M. D. or other

Address: Westernport, Md Date signed: 12-26-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1941
BUREAU V. S.